



BIRTH CONTROL STRATEGIES IN DISASTER PRONE SETTINGS IN INDIA

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INDIAN OCEAN TSUNAMI 2004

Coastline of Tamil Nadu, Kerala,
Andhra Pradesh,
Pondicherry and Andaman and
Nicobar Islands of India

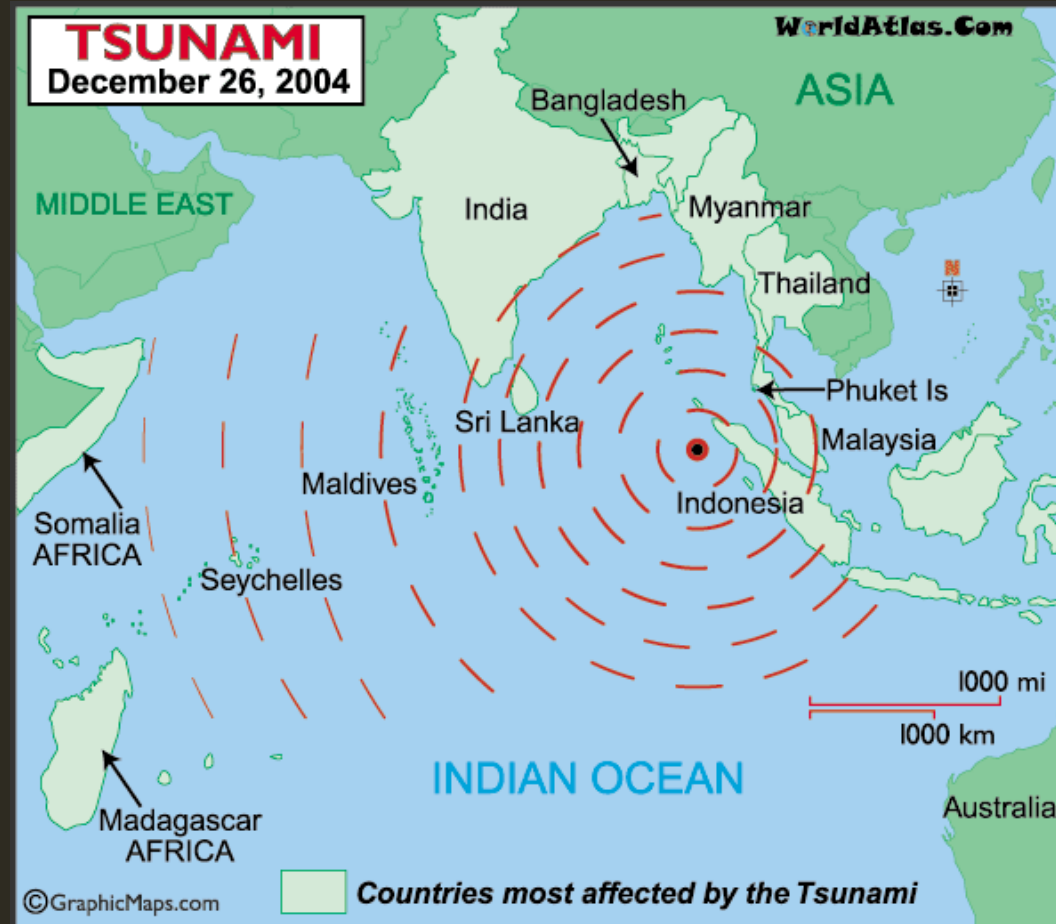
10,749 deaths

5,640 persons missing

2.79 million people affected

11,827 hectares of crops damaged

300,000 fisher folk lost their livelihood



CHILDREN



2,300 children under age 18 in Tamil Nadu lost their lives.

Nagapattinam, a coastal district of 1.4 million people where the tsunami left 6,065 dead, including 1,776 children.

LOSS, GRIEF AND RECOGNITION

Losing a child is a disastrous event for parents. They loved them , they wanted their children back. However, most of the women who lost their children are already sterilised. India is known for the radical sterilisation program where women are sterilised by the health professionals easily either by force or coercion.

Apart from personal loss, the recognition, social prestige and security associated with having children pushed the women to look for having children again.



BIRTH CONTROL

Birth control programmes focuses mainly only with women

Restricting their capacity to reproduce in order to control the population ie. National issue than personal especially with the poor and the marginalised.

Tubectomy is the main tool, two-thirds of India's female contraceptive users rely on tubectomy.

By 2002, nearly 44 percent of Tamil Nadu's women had borne two children and been sterilized before their 27th birthday. And the state's total fertility rate dropped from 3.8 in 1976 to 2.0 in 2002

Majority of the women who lost their children in tsunami are mid aged and sterilised.



RECANALISATION — POST TSUNAMI RELIEF

The state government provided free reversals of tubal ligation for women there who wish to conceive again.

Tamil Nadu's chief minister, J. Jayalalithaa, added a political gloss to the drive by appearing on television to publicize an executive order that promised either free recanalizations at government hospitals or 25,000 rupees (\$595) in compensation for those who opt for private clinics.



RISKS AND BENEFITS

It is viewed as a reproductive right based approach.

Some criticised that it reemphasises the women's reproductive based identity by bearing children which poses huge burden on them to have kids again to sustain their family/husband.

For example Sujatha Natarajan, vice president of the Family Planning Association of India said “This is about societal pressure on a childless parent. And that's not the right reason to have a child”.

RISKS AND BENEFITS

There is also no guarantee that all of these operations will result in healthy pregnancies: One public hospital in Chennai that specializes in the procedure reports that just 47 percent of its recanalization patients eventually gave birth again. In fact, Chankath, state health secretary said that many reversals could be doomed because government doctors often cut too much of the fallopian tube during the original tubectomy in order to forestall legal claims of method failure.

The success rate is 30 per cent and the risk of defects or congenital malformation in the baby increases when couples are above 35

HOPE

Still, officials believe that recanalization brought fresh hope to bereaved couples. At Kilpauk Medical College Hospital in Chennai, surgeon A. Kalaichelvi considers 24-year old Sumathy, a fish vendor from the town of Mahabalipuram, one of the lucky ones. Sumathy, who lost her 7-year-old son to the tsunami, had her recanalization performed by Kalaichelvi a month ago.

“I feel at peace,” says Sumathy, perched on a blue hospital mattress. “My mother-in-law said, in future, when you grow old, you need a child to be there.”

HOPE

Parameshwari Bose of a village near Nagapattinam town wants to reverse her sterilisation to become a mother again as she has lost all her four children to last year's tsunami.

Most other women like her, who had undergone sterilisation earlier as part of a family planning drive, are now looking to the recanalisation option.

INTERESTING INTERVENTION

The Government introduced this programme to pacify the women who lost children. Good amount of women underwent recanalization and bore children as they wished.

This case provoked interest in reproductive health in disaster settings

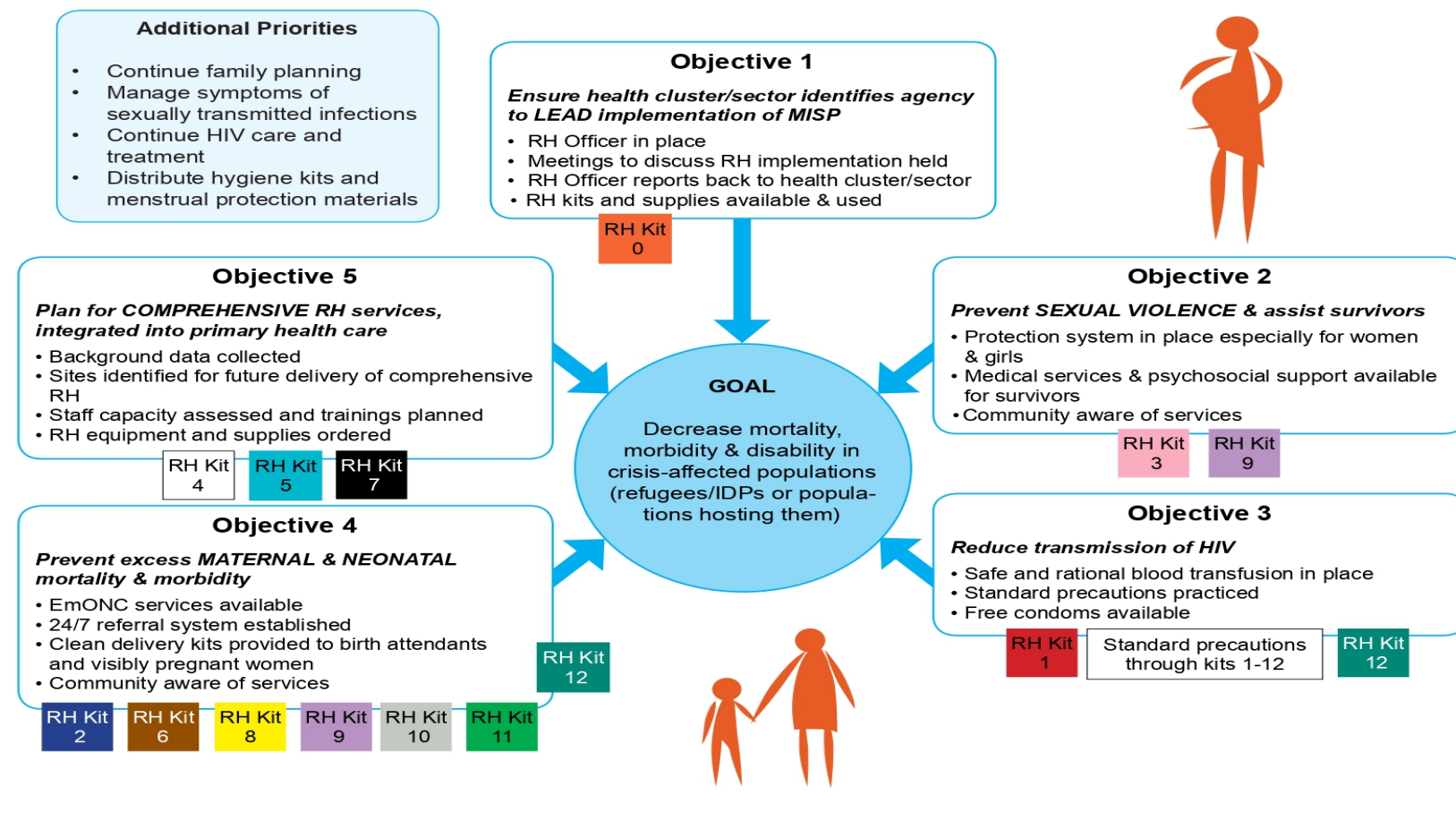
Is there a model, tool available for reproductive health in disaster settings?

Minimum Initial Service Package (MISP) is created and used in predominantly man made disasters settings (Bosnia, Albania, Macedonia, Sierra Leone, Liberia, and Congo)

MISP can lead the way forward to address the issue of reproductive health in natural disaster settings

MISP

Minimum Initial Service Package (MISP) for Reproductive Health



MISP

	CRISIS	POST-CRISIS/PREPAREDNESS	The RH Kit is designed for use for a 3-month period for a varying population number and is divided into three "blocks" as follows:		
	Crude mortality rate >1 death/10,000/day	Mortality returns to level of surrounding populations	Block 1: Six kits to be used at the community and primary health care level for 10,000 persons / 3 months		
SUBJECT AREA	MINIMUM (MISP) RH SERVICES	COMPREHENSIVE RH SERVICES	KIT NUMBERS	KIT NAME	COLOR CODE
FAMILY PLANNING	<ul style="list-style-type: none">• Provide contraceptives, such as condoms, pills, injectables and IUDs, to meet demand	<ul style="list-style-type: none">• Source and procure contraceptive supplies• Provide staff training• Establish comprehensive family planning programs• Provide community education	Kit 0	Administration	Orange
			Kit 1	Condom (Part A is male condoms + Part B is female condoms)	Red
			Kit 2	Clean Delivery (Individual) (Part A + B)	Dark blue
			Kit 3	Rape Treatment	Pink
			Kit 4	Oral and Injectable Contraception	White
GENDER-BASED VIOLENCE	<ul style="list-style-type: none">• Coordinate mechanisms to prevent sexual violence with the health and other sectors/clusters• Provide clinical care for survivors of rape• Inform community about services	<ul style="list-style-type: none">• Expand medical, psychological, social and legal care for survivors• Prevent and address other forms of GBV, including domestic violence, forced/early marriage, female genital cutting,• Provide community education• Engage men and boys in GBV programming	Kit 5	STI	Turquoise
			Block 1 contains six kits. The items in these kits are intended for use by service providers delivering RH care at the community and primary care level. The kits contain mainly medicines and disposable items. Kits 1, 2 and 3 are subdivided into parts A and B, which can be ordered separately.		
			Block 2: Five kits to be used at the community and primary health care level for 30,000 persons / 3 months		
			KIT NUMBERS	KIT NAME	COLOR CODE
			Kit 6	Clinical Delivery Assistance (Part A + B)	Brown
MATERNAL AND NEWBORN CARE	<ul style="list-style-type: none">• Ensure availability of emergency obstetric and newborn care services• Establish 24/7 referral system for obstetric and newborn emergencies• Provide clean delivery packages to visibly pregnant women and birth attendants• Inform community about services	<ul style="list-style-type: none">• Provide antenatal care• Provide postnatal care• Train skilled attendants (midwives, nurses, doctors) in performing emergency obstetric and newborn care• Increase access to basic and comprehensive emergency obstetric and newborn care	Kit 7	IUD	Black
			Kit 8	Management of Complications of Abortion	Yellow
			Kit 9	Suture of Tears (Cervical and vaginal) and Vaginal Examination	Purple
			Kit 10	Vacuum Extraction for Delivery (Manual)	Grey
			Block 2 is composed of five kits containing disposable and reusable material. The items in these kits are intended for use by trained health care staff with additional midwifery and selected obstetric and neonatal skills at the health centre or hospital level.		
Block 3: Two kits to be used at referral hospital level for 150,000 persons / 3 months					
STIs, INCLUDING HIV, PREVENTION & TREATMENT	<ul style="list-style-type: none">• Ensure safe and rational blood transfusion practice• Ensure adherence to standard precautions• Guarantee the availability of free condoms• Provide syndromic treatment as part of routine clinical services for patients presenting for care• Provide ARV treatment for patients already taking ARVs, including for PMTCT, as soon as possible	<ul style="list-style-type: none">• Establish comprehensive STI prevention and treatment services, including STI surveillance systems• Collaborate in establishing comprehensive HIV services as appropriate• Provide care, support and treatment for people living with HIV/ AIDS• Raise awareness of prevention, care, treatment services of STIs	KIT NUMBERS	KIT NAME	COLOR CODE
			Kit 11	Referral level for Reproductive Health (Part A + B)	Fluorescent Green
			Kit 12	Blood Transfusion	Dark Green
			Block 3 is composed of two kits containing disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. Kit 11 has two parts, A and B, which are usually used together but which can be ordered separately.		
			NOTE: Agencies should not depend solely on the Inter-agency RH Kits and should plan to integrate the procurement of MISP/RH supplies in their routine health procurement systems.		

“THEY MAY THINK, WHY GET STERILIZED? A TSUNAMI MIGHT COME AGAIN.”

While many health experts doubt that the tsunami will significantly alter the Indian government's longstanding focus on tubectomy, they feel the disaster could prompt some second thoughts among coastal dwellers. Says Dr. Manorama: “They may think, why get sterilized A tsunami might come again.”

Yes, people are having second thoughts nowadays...



WHAT'S SIGNIFICANT IN DISASTER SETTINGS

Disaster management leads with volunteers than professionals

“Ethics is luxury” perspective – this leads to unaccountable practice and research

India is the hotbed of unethical practice in health and clinical research , in disaster settings its worse.

Ethical practice and ethical research is the need but here is no organised structure to monitor and execute ethical research and practice in disaster settings

Very limited IRBs and ethics committees which are very much part of an academic environment

Very few resources. Yet, not mainstreamed for example MISP

POLICY RECOMMENDATIONS

“People affected by humanitarian crises deserve responses that promote health, respect dignity, and uphold rights” Mathuna D and Siriwardhana C. But the ultimate challenge is ensuring the rehabilitation with dignity and rights.

Have to remove radical sterilisation among the vulnerable population in disaster settings

Inform people to adopt for easily reversible contraceptive methods pills, IUDs, and condoms

Make MISP very much part of public health system and healthcare professional training

Integrate ethics into the practice and the research of every public health intervention including disaster settings.

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